STATE OF CONNECTICUT

INSURANCE DEPARTMENT

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Testimony of the Connecticut Insurance Department
Before
The Insurance and Real Estate Committee

Tuesday, March 9, 2010

Raised Bill No. 393--An Act Concerning Standards in Health Care Provider Contracts

The Connecticut Insurance Department would like to offer the following comments on Raised Bill 393 – An Act Concerning Standards in Health Care Provider Contracts.

At the outset the Department respectfully urges the Committee to proceed cautiously on this bill, because it includes a number of complicated, unrelated issues which all merit independent analysis.

Section 1 – This section of the bill relates to the statutory time period a health insurer, health care center or other entity has to process a complete health insurance claim.

The Department supports generally reducing the time period from 45 days to a shorter time, and also to have a shorter time frame for electronic claims than for paper claims. However, it is hard to comment further without knowing the exact time frames that are being considered. We would like to work further with the Committee on this section. We also suggest that any statutory time frame for electronic claims begin with receipt by the insurer, rather than sending by the provider.

Sections 2 and 3 - These sections require the Department to establish procedures related to solicitation of network providers by health insurers, health care centers and other specified entities and maintenance of provider participation in such networks (section 2), as well as establish provider network adequacy standards (section 3).

The Department is opposed to these provisions because we do not have expertise in these areas. The Department's expertise is in regulating insurance companies and the policies and group certificates they issue to their policyholders. Historically we have had little involvement in issues involving provider contracts between Managed Care Organizations (MCOs) and participating providers. It would be difficult for the Department to establish provider network adequacy standards that would apply to rural and urban areas, various types of medical practitioners, including general practitioners, ob/gyn practitioners, various specialists, chiropractors, and other licensed medical practitioners, as well as acceptable travel limits and other factors, over which reasonable people could disagree. In addition it appears the intent of the bill language is that the standards would further vary by the type of specified health insurance under the different subdivisions (1),(2),(4), 11) and (12) of section 38a-469 of the general statutes.

Similarly, the Department has had no involvement to date in solicitation of providers by an MCO or of maintenance of provider participation. The Department anticipates that the volume of complaints from providers (particularly those not accepted into a network) may increase

dramatically. More Department manpower will be needed with this expertise in order to develop the procedures for soliciting health care providers, providing on-going monitoring of provider participation in networks, establishing and evaluating network adequacy standards for the insurers in the state, and providing a grievance review for provider groups as well as consumers who challenge network adequacy determinations.

Section 4 – This section provides that a utilization review entity may not refuse to pay for a medical treatment or service, where the policyholder has obtained the treatment or service in detrimental reliance upon the authorization of the review entity.

The Department wants to indicate as a technical comment that in many, if not most instances, the utilization review entity is not the entity paying the claim. In some instances, the health insurer or health care center is licensed as a utilization review entity and performs the utilization review itself. However, more frequently, a health insurer or health care center retains a licensed utilization review entity to perform these services on its behalf.

The Department supports the general concept that the claim should not be denied after there is detrimental reliance by an insured on a favorable utilization review determination. However, we wish to point out that a "hard and fast" rule may not be appropriate in all circumstances. By nature of the utilization review process, medical necessity determinations are made in advance of services being provided. Between the time of medical review and the date of service, (a) the member may no longer be covered under the plan, (b) the requested service may have reached its benefit limit or (c) an employer may have changed plans or health insurers, and there may be substantially different limits of coverage than the plan in place at the time of the utilization review determination. These variables cannot be predicted at the time of medical necessity review. Despite this fact, the health insurer or health care center would be responsible for payment of the claim in these situations, under the current bill language.

Section 5 – This section seeks to establish a rule similar to the rule in section 5. It would apply to a health insurer, health care center, or other specified entity that pre-authorizes a treatment or service, other than through a utilization review entity.

The Department suggests deleting this section and making appropriate changes to section 4 instead. This section is not accurate, inasmuch as health insurers do not perform utilization review outside the utilization review law, as indicated in 4 above.

Section 6 – This section in substance provides that participating dentist contracts may not include any provisions requiring a dentist to accept a negotiated rate on a non-covered service. The Department believes this provision to be anti-consumer. As an example, an insured may go to a participating dentist for treatment and find a specific service (such as an implant or crown) is not covered. The consumer's expectation, in going in-network, is that he or she will get the benefit of a network rate, not full billed charges.